Testimony of
Cynthia Wainscott

for the

National Mental Health Association

before the

Food and Drug Administration (FDA)
Psychopharmacologic Drugs Advisory Committee and
Pediatric Advisory Committee

September 13, 2004

I am Cynthia Wainscott. I appear before you on behalf of the National Mental Health Association (NMHA), the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. I am privileged to serve as chair of NMHA's board of directors. Today I appear not only as an NMHA leader but as a daughter, mother and grandmother, who has experienced depression in three generations of my family. I am eager to share my perspective on this illness and the role that FDA, together with other federal agencies, must play in helping people, and particularly children, obtain safe and effective treatment.

I want to thank you on behalf of NMHA for your efforts to ensure the safety of America's children. In particular, we appreciate your review of reports of the occurrence of suicidality (both suicidal ideation and suicide attempts) in clinical trials for various antidepressant drugs in children with major depressive disorder and other psychiatric disorders.

We are deeply committed to the availability of the best treatments for the millions of children who have mental illnesses, and are hopeful that this public advisory meeting is a step in that direction.

NMHA urges FDA and other policymakers to consider these issues in a broad context. For too long, mental illness and mental and emotional disorders among children and adolescents remained a subject in the shadows. The landmark 1999 report, *Mental Health: A Report of the Surgeon General*, helped bring greater attention and understanding to this issue. We know today that such disorders are widely prevalent among children. The Surgeon General reported that about 20 percent of children are estimated to have mental disorders with at least some level of functional impairment, and that 5 to 9 percent of youth have mental disorders that severely disrupt their ability to function socially, academically, and emotionally.[1] And it is not uncommon

[1] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. 1999.

for a youngster to have multiple mental disorders, such as attention deficit hyperactivity disorder (ADHD), co-occurring with depression.

Treatment efficacy and safety are vital issues. Yet these important concerns must not eclipse **the shocking crisis of children's mental health: while an estimated four million American youth have a major mental illness that significantly impairs home life, school functioning, and peer relationships, less than one-third of children who need mental health treatment receive any services at all, and even fewer receive appropriate care**.[2] The failure to provide these children appropriate mental health interventions can disrupt their social and educational development, and lead to academic failure, substance abuse problems, or juvenile justice involvement. In fact, a staggering 80 percent of young people in the juvenile justice system have a mental illness, according to the President's New Freedom Commission on Mental Health.[3] A recent Congressional study found that nationwide, juvenile justice facilities spend an estimated $100 million each year to house youth simply because they are waiting for community mental health services.[4]

Mental illness is the leading cause of disability and premature death in this country. Yet we have made little progress as a nation in toppling the barriers to needed treatment -- barriers that are especially high for children. That tragedy, in our view, is but one facet of this country's failure to make mental health a national priority. In fact, the President's mental health commission characterized that failure as a national tragedy, citing – as just one example – the 30,000 suicide-deaths each year in this country as a preventable public health crisis.[5] Mental disorders are implicated in 90 percent of those cases, according to the Institute of Medicine, which reported in 2002 that suicide is the third leading cause of death among youth.[6] Each year, approximately 500,000 adolescents in the United States attempt suicide. Almost 2000—half of whom suffer from major depression—die as a result.[7] **Untreated childhood depression, with its risk for suicide, is clearly a serious public health problem.**

Thus, while we salute FDA for highlighting an important issue, we urge the agency to engage the Secretary and other policymakers to make children's mental health a government-wide priority, and to approach the safety and efficacy issues in the broadest possible context.

---

[2] Ibid.
[3] President's New Freedom Commission on Mental Health. *Interim Report of the President's New Freedom Commission on Mental Health*. 2002.
[4] U.S. House of Representatives Committee on Government Reform—Minority Staff, Special Investigations Division. *Incarceration of Youth Who Are Waiting for Community Mental Health Services in the United States*. 2004.
[5] President's New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. 2003.
[6] National Academy of Sciences, Institute of Medicine. *Reducing Suicide: A National Imperative*. 2002.
[7] Arias et al. (2003), Gould et al. (1998) and Schaffer et al. (1996), as cited in: March, J. et al. Fluoxetine, Cognitive-Behavioral Therapy, and Their Combination for Adolescents with Depression: Treatment for Adolescents With Depression Study (TADS) Randomized Controlled Trial. *Journal of the American Medical Association*, Vol. 292, No. 7. August 18, 2004.

FDA Actions and Research Developments

We recognize that several developments have occurred since FDA initiated its review of antidepressant drugs in children. Among these developments, we welcome FDA's March 22nd Public Health Advisory, which -- based on the recommendation of advisory committees -- announced that it was asking manufacturers to add warning statements to the labeling of certain drugs to include stronger cautions and warnings about the need to monitor patients for worsening of depression and the emergence of suicidality. The FDA advisory also warns clinicians to closely observe patients being treated with antidepressants for clinical worsening and suicidality, especially at the beginning of a course of therapy, or at times of dose changes. The advisory also warns clinicians to consider changing the therapeutic regimen in patients whose depression is persistently worse or in whom emergent suicidality is severe, abrupt in onset, or was not part of the patient's presenting symptoms. Importantly, FDA also advised families and caregivers to be alert to the emergence of specific symptoms, and to report such symptoms to their health care providers.

NMHA commends the Food and Drug Administration for these actions. It is particularly noteworthy that the FDA advisory emphasized that good clinical practice, namely closer monitoring, should be the norm in all patient care. The sad reality is that in many health care settings, even this fundamental knowledge about appropriate patient care does not translate into clinical practice. We applaud the FDA for its efforts to address this problem.

As a result of its review, FDA also concluded that there was a need for greater clarity about suicidal behavior and for consistent terminology to describe it. To that end, the agency arranged for an independent review of research data in order to analyze adverse events in a systematized manner.

While this FDA initiative has sparked a re-examination of the confusing thicket of earlier clinical trials of SSRIs and other antidepressants in pediatric patients, those searching for answers are the beneficiaries of an important, recently published research study funded by the National Institute of Mental Health. The Treatment for Adolescents with Depression Study (TADS) examined the effectiveness of one of the SSRIs (fluoxetine), alone and in combination with a form of psychotherapy (cognitive behavioral therapy), on treating major depressive disorder (MDD) in adolescents.

The study's findings mirrored the experience of many children and families—that a combination of medication and psychotherapy was most effective in treating adolescent depression. In addition to recommending that the identification of depressed adolescents and provision of evidence-based treatment be mandatory in health care systems, the study's authors concluded that "despite calls to restrict access to medications, medical management of MDD with fluoxetine, including careful monitoring for adverse events, should be made widely available, not

discouraged' and that "CBT [cognitive behavioral therapy] also should be readily available as part of comprehensive treatment for depressed adolescents."[8]

The study's findings highlight the need for increased access to effective mental health interventions, not restricted access. At the same time, much more research needs to be done to understand which adolescents are most likely to benefit from which therapies, and which are most likely to experience adverse events. The tragic reality – one that NMHA has highlighted for years – is that far too little research has been done on the safety and efficacy of medications for children. NMHA was a supporter of the Pediatric Research Equity Act of 2003 (P.L. 108-155), which gives FDA specific authority to require pharmaceutical companies to test the safety and efficacy of drugs in children before their products receive approval; NMHA also supported earlier efforts to create market incentives for pediatric research on medications. In addition, NMHA supports the public disclosure of all research findings on medication safety and efficacy. Clinicians, consumers of mental health services, and their families must have access to as much information as possible as they weigh the relative risks and benefits of any course of treatment.

However, if we as a nation are truly committed to advancing public health and protecting public safety, we cannot rely solely on research conducted by private industry. Federal agencies, such as the National Institute of Mental Health, also have a crucial role to play. Though there are limits inherent in any study design, the landmark TADS study is significant not only in its contribution to addressing critical public health questions, but as a model for the types of research that should be conducted on *all* psychotropic medications for children. NMHA urges the federal government to expand its leadership role in this area, and to support similar trials with all of the SSRIs, as well as other medications and psychotherapies used to treat depression in children and adolescents.

Safety

NMHA applauds the FDA for its methodical approach to reviewing data on the use of antidepressants in children, and agrees that additional government action is needed. Such action, and the public education efforts that must necessarily accompany regulatory actions, must remain focused on the enormous impact clinical depression has on children, their families, communities, and society.

We must not lose sight of the reality that untreated depression is a serious mental health problem. This illness affects as many as one in every 33 children and one in eight adolescents. We know much about this illness. Family history, stressful life events such as losing a parent or parents' divorce, and other physical or psychological problems are all factors that can contribute to its onset. Children who experience abuse, neglect, or other trauma, or who have a chronic physical illness, are at a higher risk for depression. Depression in children often occurs along with other mental health problems such as anxiety, bipolar disorder or disruptive behavior disorders. Adolescents who become clinically depressed are also at a higher risk for substance abuse

[8] March, J. et al. Fluoxetine, Cognitive-Behavioral Therapy, and Their Combination for Adolescents with Depression: Treatment for Adolescents With Depression Study (TADS) Randomized Controlled Trial. *Journal of the American Medical Association*, Vol. 292, No. 7. August 18, 2004.

problems. Once a young person has experienced an episode of depression, he or she is at an increased risk for having another episode of depression within the next five years. And it is well documented that depression in children is also associated with an increased risk for suicide. **Importantly, clinical depression is one of the most treatable medical illnesses.**

In short, if government is to respond to this illness in a manner commensurate with its impact on public health, it must tackle not only the unresolved questions of medication-safety, but the alarming barriers to treatment that continue to face so many families whose children have mental health needs, as well as the misinformation and stigma that still cloud understanding of mental illness. NMHA has worked for many years to develop the capacity and knowledge base to carry out this type of public education, including education for primary care physicians. We stand ready to work in partnership with the FDA and other federal agencies to implement such a national scale public education effort, and encourage you to support this much-needed strategy.

Scientific Advances: One Family's Success Story

With those concerns as background, I particularly want to share my own family's story. In addition to my role as a mental health advocate, I am testifying today as a daughter, mother and grandmother who has seen, firsthand, the impact of depression in three generations of my family, and what both treatment advances and stigma have meant to people I love.

My mother, a bright and loving woman, bravely struggled with depression prior to the advent of SSRI medications. Although she received the best treatment that was available then, there were long periods when she literally could not get out of bed. Twice the pain became so great that she tried to end her life. She got her first real help in her late 60s when she was on a clinical trial of an early SSRI. She told me that it was as if someone has lifted "the dark veil" for the first time since adolescence. After decades of suffering she was, in her final years, better able to engage in life and family activities. Because of the heavy stigma around mental illness she very rarely disclosed the illness that so profoundly affected her and all of us who loved her.

Also before the advent of the newer medications, my oldest daughter Tara experienced mild adolescent depression. Then as a young mother she was healthy and happy. But after the birth of her third child she rapidly developed severe post-partum depression that was debilitating. We recognized what it was. She got help, including a SSRI, and was quickly able to resume her full activities as wife and mother. She now owns a small business with her husband and is president of the PTA at her youngest daughter's school. We rejoice that a good therapist and SSRI medication allows her to manage the illness with a dramatically different outcome than Mother experienced. She matter of factly talks about her depression and her openness has helped many people understand the "no fault" character of this illness, and sometimes to recognize that they need help.

Her oldest daughter, Jessica, is an outgoing, engaging 15 year old—a grandmother's dream. As a young child she was sunny and cheerful, very loving and affectionate. However, as she turned eleven, it was clear that something was very wrong. This happy, warm child was suddenly crabby and difficult to get along with. She became withdrawn and moody. As much as we know

about depression, it did not occur to us initially that Jessica was grappling with something more significant than the onset of adolescence. We awakened to that realization as a result of a conversation she had with her father, who -- at a point of frustration -- finally approached her very directly. "Jessica," he said "you need to tell us what's the matter." She angrily replied, "I HAVE been telling you." "No," her dad answered, "you've just been going away from us." After a long silence she said, "I don't know, Dad. It seems like I am mad all the time." As she described the pain she was in, her father (who was intimate with the symptoms through his wife's experience) knew that Jessica needed professional help. She was diagnosed with depression and together she, her family, their pediatrician and a consulting psychiatrist developed a comprehensive treatment plan to help Jessica cope with the symptoms and recover. Her plan included ongoing therapy as well as SSRI medication.

I am happy to tell you that Jessica is doing extremely well. She's engaged in school, participates in drama and water sports, has a great group of friends, and is displaying a real talent for art. She is studying for her driver's license and she enjoys spending time with her family. Not many 15 year olds reach for a grandmother's hand, as she did last week, and hold it while shopping.

Jessica sticks to her treatment regimen and still takes medication. She's learned to recognize the first sign of a depressive episode and knows when she needs to slow down. She is unembarrassed to have this illness and talks about it freely and casually. The other day she told me that she could not go on an outing with me as planned because she had to go to the doctor. I said, "What is the matter?" (thinking of injury or infection). She said, "Oh, it is just the shrink. Med check." As I prepared this testimony, I talked with Jessica about it. She told me, "Be sure to tell them not to do anything that will make people afraid to seek help. Life is so much better with treatment." I asked her how it was better and she said, "I am able to just be myself without being pulled down by unseen strings." Then she told me about a good friend who has begun taking an SSRI and talked passionately about how it is helping her friend both at school and home.

I know that you will also hear family stories that do not end so well. Some families have tragic stories to share. Suicide is one of the most devastating events any family can experience, and it is a real danger with depression. NMHA applauds the FDA for its work to ensure that all people, especially children, are able to access safe, effective treatments. We very much support your call for closer monitoring of individuals taking SSRIs and your call for ongoing research.

At the same time, we must be careful that the medication debate does not overshadow our country's children's mental health crisis, and inadvertently restrict access to the care needed by so many children like Jessica. In America today many barriers to care exist, especially for children. Only one-third of the young people who need mental health treatment receive any services at all, and only about one third of those who get treatment receive appropriate care.

Jessica was lucky. Because of our earlier family experiences, we were able to recognize the need for help, and we were able to get it for her. But many families don't understand what is happening, or are confused about where to turn for help. Or they feel shame about needing help. They get conflicting messages from the media and from people that they trust. They find that schools and other institutions are limited in what they can do and say. I urge you, as Jessica asked me to, to be sure that you do not inadvertently send messages that discourage people from

seeking treatment. And we must be sure that primary care physicians do not get messages that make them hesitant to engage in important discussions about mental health. Left untreated mental illness can and does lead to school failure, substance abuse, involvement with the juvenile justice system and even suicide. With effective treatment, I have seen three miracles occur.

The "Medication Debate" Misses the Point

The "medication debate," which has played such a large role in shaping attitudes about treating depression in children, misses a critical point implicit in FDA's March advisory materials. Successful management of depression, particularly in children, is not solely a matter of taking medication. It requires the development of an individualized treatment plan (often including a combination of therapies), regular interaction between clinicians and families, and education for youth and families that enable them to make informed choices and to monitor their clinical outcomes, including knowing how to immediately identify and address any adverse events.

An editorial accompanying the publication of the TADS study highlights the point. "Probably the most important message from TADS," JAMA's Deputy Editor, Richard M. Glass, M.D., wrote, "is that carefully assessed, empirically validated treatments are available for adolescents with major depression... The results from this major new trial demonstrate that although treatment of a depressive illness is often successful and gratifying for patients and clinicians, such success typically requires more than a brief visit for prescription of medication. Rather, it requires careful assessment and monitoring in the context of an ongoing patient-physician relationship. Furthermore, the current evidence suggests that the likelihood of a good outcome is enhanced by the combination of appropriate and carefully monitored drug treatment with an empirically validated psychotherapy."[9]

For adolescents with major depression, lack of access to mental health care is dangerous and even life-threatening. Effective treatment can make the difference between success and failure in school, between effective and impaired social functioning, between community participation and isolation, between life and death. In its communications regarding children's mental health, as well as in its policymaking, we urge the FDA to address not only the safety of medications for children, but the critical challenge of making safe, effective, comprehensive mental health care accessible to all children who need it

[9] Glass, R. Treatment of Adolescents with Major Depression: Contribution of a Major Trial. *Journal of the American Medical Association*, Vol. 292, No. 7. August 18, 2004.